DOCUMENT RESUME

ED 439 558 EC 307 737

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TITLE Home Visiting: Reaching Babies and Families "Where They Live." A Report of the Best Available Information from 20 Years of Research and Practice on Home Visiting.
INSTITUTION Zero to Three: National Center for Infants, Toddlers and Families, Washington, DC.
ISBN ISBN-0-943657-40-7
PUB DATE 1999-03-00
NOTE 20p.; Supported by the Freddie Mac Foundation.
AVAILABLE FROM ZERO TO THREE, National Center for Infants, Toddlers and Families, 734 15th St., N.W., Suite 1000, Washington, DC 20004-1013. Tel: 800-899-4301 (Toll Free); Tel: 202-638-0840; Fax: 202-638-0851; Web site: http://www.zerotothree.org.
PUB TYPE Guides - Non-Classroom (055)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Agency Cooperation; Child Rearing; Community Health Services; *Disabilities; Early Intervention; Financial Support; *Home Instruction; Home Programs; *Home Visits; Infants; *Outreach Programs; Parent Child Relationship; *Parenting Skills; Professional Development; *Program Design; Program Evaluation; Toddlers

ABSTRACT

This report discusses home visiting, identifies six key elements common to programs for infants and toddlers that make effective use of home visiting strategies, and profiles successful home visiting programs. It begins by discussing home visiting services and outcomes of home visiting programs. The six key elements of effective home visiting are then presented and include: (1) clearly defined goals and objectives; (2) home visitors who know how to reach the goals and objectives; (3) carefully recruited and well-trained home visitors; (4) collaboration with other community resources; (5) adequate and stable funding; and (6) evaluation and continuous quality improvement. The report then profiles the Clinical Nursing Models Project, the Enrichment Using Natural Resources in the Community and Home (ENRICH) program, the Healthy Families America program, the Healthy Steps for Young Children program, the Infant-Parent Program, the Ounce of Prevention Fund, the Parents as Teachers program, the Prenatal and Infancy Nurse Home Visitor Program, the Steps toward Effective, Enjoyable Parenting program, and the Family Development Project. Included in each profile is information on the history and an overview of the specific project, the service delivery model used, staffing and professional development, community collaboration, evaluation/research, and the funding source. (Contains 36 references.) (CR)

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HOME VISITING

Reaching Babies and Families "Where They Live"

A REPORT OF THE BEST AVAILABLE INFORMATION FROM 20 YEARS OF RESEARCH AND PRACTICE ON HOME VISITING

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We express our gratitude to
The Freddie Mac Foundation for generously funding this effort and to the following individuals for reviewing drafts of this document and sharing their thoughtful insight and expert knowledge of home visiting.

We also wish to thank the Pritzker Cousins Foundation for enabling us to convene this esteemed advisory group.

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ISBN 0-943657-40-7
Printed in the United States of America
First Printing, March, 1999

Writers: Stefanie Powers and Emily Fenichel
Photo Credits: Marilyn Nolt, pgs. cover, 5, 6, 8, 9, 10, 11, 14; Andres R. Alonso, pgs. 7,13; Janet Brown McCracken, p. 15

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HOME VISITING: REACHING BABIES AND FAMILIES "WHERE THEY LIVE"

"FAMILY MEMBERS OFTEN GIVE YOU ADVICE AND TELL YOU WHAT YOU'RE DOING WRONG. (MY HOME VISITOR) LISTENS TO ME, SHE LETS ME KNOW HOW COMPETENT A MOTHER SHE THINKS I AM, SHE OFFERS ME SUGGESTIONS AND NEW IDEAS. TO ME THE RELATIONSHIP THAT (SHE) AND I HAVE BUILT (WHILE I WAS PREGNANT), AND THAT SHE THEN EXTENDED TO MY SON, HAS BEEN THE MOST IMPORTANT THING... IT HAS TRULY ENRICHED MY LIFE AND MY SON'S LIFE."

31-YEAR-OLD SINGLE MOTHER IN TESTIMONY BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES, JULY 1998

Policy makers, program developers, administrators, and funders make decisions every day about home visiting that are critical to any program's potential effectiveness. To help decision makers invest wisely in initiatives to improve the lives of children and families, ZERO TO THREE: National Center for Infants, Toddlers and Families has prepared this report of the best available information from 20 years of research and practice on home visiting and identified six key elements common to programs for infants and toddlers that make effective use of home visiting strategies.

WHAT IS HOME VISITING?

Home visiting is a strategy for offering information, guidance, and emotional and practical support directly to families in their homes. Home visiting has been an effective strategy for delivering services for more than a century; during the past 20 years it has experienced a tremendous increase in popularity. Today, home visiting is a part of programs as diverse as health care, parenting education, child abuse prevention and early intervention for young children with disabilities.

All expectant parents and families with newborns and very young children deserve their community's support. Home visiting, offered on a voluntary basis, is one way communities are reaching out to those who want that help. Families vary widely in the amount and kind of assistance or services they need to give their babies the best possible start in life. Many expectant parents or families with infants and toddlers welcome the opportunity to get information, guidance, and support for parenting "where they live" — in their homes.

Home visiting is not a service in itself — it is a strategy for delivering services. Service programs that use home visiting may have one or more goals, such as:

- improving pregnancy outcomes;
- improving child health outcomes;
- teaching parents about early development;
- enhancing the parent-child relationship;
- enhancing parents' competence, confidence, and autonomy;
- enriching the home environment to encourage young children's learning;
- decreasing social problems, such as poverty, crime, and delinquency;
- preventing child abuse and neglect;
- identifying and treating children with special health care needs, developmental delays, or disabilities; or
- increasing families' appropriate use of community resources.

WHY IS HOME VISITING UNIQUE?

Home visiting reaches families where they live. Families who have difficulty using community services that are based in offices, schools or hospitals find home visiting to be an effective way to receive information, guidance and support. Some expectant parents and families with infants and toddlers benefit from home visiting because service providers can:

- reach families who live far away or lack transportation to clinics or service centers;
- respond to the needs and interests of individual families by working flexible or non-traditional hours;
- deliver their services in

EVERYONE THINKS I SHOULD KNOW WHAT TO DO BECAUSE WE HAVE TWO OTHER CHILDREN, BUT WHAT I REALLY NEED IS SOME POSITIVE FEEDBACK TO KNOW I AM DOING THINGS RIGHT.

HEALTHY STEPS PARENT, BOSTON, MASSACHUSETTS

an environment that may not be as unfamiliar or threatening to both children and their parents as a typical office or clinic;
- learn more about families' circumstances, strengths, and needs when they see parents and children interacting in their home environment; and
- build strong, trusting, personal relationships with families — an important element in the overall effectiveness of any program of support.

The Impact of Home Visiting

Researchers are continuing to gather evidence about what aspects of providing services through home visiting work well for whom, and under what conditions. This information will help to strengthen existing programs and develop new models to serve diverse families and communities more effectively.

The question of how home visiting strategies are best evaluated has been a challenging one. While randomized, controlled clinical trials have long been the scientific "gold standard," many types of evidence help us to explore what works, what is promising, and what deserves future exploration. Rigorously controlled studies published in peer-reviewed scientific journals provide the strongest evidence regarding how services provided through home visiting make a positive difference in the lives of children and families. Other evaluation methods produce less certainty about cause-and-effect relationships yet offer rich sources of information that can help policy makers invest wisely in services for children and families.

YOU CAME IN MY NEIGHBORHOOD, YOU WEREN'T AFRAID. THAT REALLY FELT GOOD THAT SOMEBODY CARED ENOUGH TO COME AND SEE US. I WAS REALLY SURPRISED AND TAKEN ABACK THAT, YOU KNOW, YOU CAME TO MY NEIGHBORHOOD AND TO SEE ME. AND THE WALLS STARTED TUMBLING DOWN, AND I COULD TRUST A LITTLE BIT MORE.

T.J., San Francisco, California

A Review of Six National Home Visiting Models

Home visiting is not a panacea for all the ills of society. The David and Lucile Packard Foundation recently reviewed the accumulated research on six national programs that have been rigorously studied in randomized, controlled trials and discovered mixed results and wide variation in how programs were implemented.[1] No one service program can or should be expected to inoculate families against the varied and complex needs facing children and families today. Existing programs that use home visiting to deliver services to expectant parents and families with infants and toddlers should build upon what has been learned from these results to create programs with the greatest potential for success.

A Model Program of Research on Nurse Home Visitation

One exemplary program of research on a model program of nurse home visitation now has 20 years' worth of evidence concerning its effectiveness. Low-income, unmarried women in a rural area of New York state who had received nurse home visits during pregnancy and the first two years of their children's lives were compared to similar women who were randomly assigned to receive comparison services, such as free screening and referrals for their children and free transportation to prenatal and well-child medical visits. Assessments when the baby reached two years of age revealed that mothers who participated in the program had fewer verified reports of child abuse and neglect and were less likely to physically punish their children; their babies were less likely to be victims of accidents and poisoning and had fewer trips to the emergency room than did babies in the comparison group of families who did not receive the nurse home visits.[2] An urban replication of this study showed that women who were visited by nurses also attempted breastfeeding more regularly, provided home environments that were more conducive to their children's intellectual and emotional development, and had more realistic expectations and greater empathy for their children.[3]

Follow-up of the program has revealed long-term benefits to participating mothers and their children. At the time of their oldest child's 15th birthday, the mothers who received nurse home visits had experienced:
- 30 fewer months on welfare;
- 27 months' greater spacing between first and second births;
- 33% fewer subsequent births;
- 81% fewer arrests and convictions; and
- 79% fewer verified cases of child abuse and neglect.[4]

Compared to their counterparts who had received services that did not include home visiting by nurses, the 15-year-old children born to mothers in the nurse home visitation program had:
- 60% fewer instances of running away;
- 56% fewer arrests; and
- 81% fewer convictions or violations of probation.[5]

Home Visiting in Comprehensive Programs of Support

A team of researchers recently reviewed 15 randomized-trial and group-comparison studies that used home visiting as an important part of a program of services for families with infants and toddlers.[7] Home visiting services in most of these studies were embedded in comprehensive programs of support, which included center-based early education, social services, and occupational training; thus it is difficult to ascribe the outcomes for participating children and families to home visiting alone. Yet parents who participated in these programs, many of whom were caring for premature infants, were better able to respond to the needs of their children, and stronger parent-child relationships led to concrete benefits for the children - more conversation between parent and child, greater exposure to learning opportunities, and more involvement in learning tasks.

What Policy Makers Can Do to Support Effective Home Visiting

The following two critical questions and six key elements of program effectiveness reflect what the research has revealed to date as beneficial to young children and their families and provide a guide for policy makers on how to invest wisely in home visiting today.

Two Critical Questions

Community representatives, program developers and policy makers should ask themselves and each other two critical questions before they launch or expand a program for families with very young children that includes voluntary home visiting.

1. *What do we want to accomplish with our program as a whole?*
2. *How will delivering services through home visiting help us reach our goals?*

Once the goals of a program for families with infants and toddlers are clear and the decision has been made that home visiting is likely to be an effective strategy for service delivery, it is time to make policy choices that will create and sustain the strongest possible program. The six key elements of effectiveness in home visiting listed below are based on a review of 20 years of research on successful programs for young children and consultation with leading experts who design, implement, and/or evaluate programs that use home visiting as a service delivery strategy.

Six Key Elements of Effective Home Visiting

I. Clearly Defined Goals and Objectives

Effective programs for expectant parents and families with infants and toddlers vary widely in what they hope to accomplish. All programs should be able to clearly articulate their overall goals and their reasons for offering home visiting as a strategy for delivering services. For example, the program goal may be to increase the percentage of babies born in the community who are full-term and healthy. Program planners may decide to target services to teen mothers who have little social support, with the belief that a home visitor who can maintain a trusting relationship with a young woman during her pregnancy, at the time of delivery, and during the baby's first two years of life is likely to help her get and use the health care she needs for herself and her child.

Participants at every level of a program — including managers, staff, and families — need to agree on their goals and objectives, and on what home visitors are expected to accomplish. It is equally important to consider how the goals of a program for expectant parents and families with infants and toddlers match the needs of participating families—as they see and express their needs initially, or as they come to embrace new possibilities for themselves through their relationship with their home visitor. Written guidelines or operational manuals help specify and reinforce these goals.

II. Home Visitors Who Know How to Reach the Goals and Objectives

The goals the home visitors are working toward will determine what they do in the home, which family members are involved, how often they visit, how long the visits last, and the kind of training and ongoing supervision they need to do the job. Home visitors need clear guidance regarding the specific activities they are expected to engage in with families in order to succeed in helping families reach their intended goals. Home visitors must be able to tell families what they can hope to get out of their participation in the sponsoring program, and what their responsibilities are as program participants.

SHE (THE HOME VISITOR) NEVER LEFT THE HOUSE WITHOUT TELLING ME, "YOU ARE DOING AN IMPORTANT JOB. IT IS VERY HARD WORK, AND YOU ARE DOING IT WELL." I ALWAYS WAITED FOR HER TO SAY THAT.

C.K., St. Louis, Missouri

III. Carefully Recruited and Well-Trained Home Visitors

Any service program is only as good as the people who staff it. Programs that use home visitors to deliver services need to decide what educational, professional, and personal experiences home visitors will need to accomplish program goals. Researchers are beginning to appreciate the unique qualities that make home visitors effective.[9] Home visitors who have been professionally trained in such fields as nursing, social work, or education, will need different kinds of orientation, training, and supervision than home visitors without that experience. Home visitors at all levels of professional development need regular, supportive supervision to be successful in their jobs. All home visitors need opportunities to refresh and expand their skills, and to advance within the program. These supports are critical to retaining the skilled staff required for this demanding work.

IV. Collaboration with Other Community Resources

Home visitors and programs that use home visiting serve families best by collaborating with other community resources that support infants, toddlers, and families. Families are complex, and no one program can meet the multiple and varied needs of each family. Effective programs have the potential to help create or be a part of a continuum of services for children and families in a community. Home visitors are more effective when their services are linked to a broader system of care, such as health, education, child development programs, or social services. In fact, the success of a program that uses home visiting may be dependent upon the quality of the community supports that are available to the participating families and their children.

V. Adequate and Stable Funding

To meet their objectives successfully, programs need adequate, stable funding. Budgets need to include sufficient resources to: pay staff salaries that reflect their level of responsibility; pay for training, ongoing supportive supervision, and professional development of staff; and cover the cost of time spent in consultation and collaboration with other community resources. Funds are needed for evaluating the program at regular intervals, including the home visiting component, and for continuous improvement, so that lessons learned can be incorporated into practice.

Stable funding allows programs the time to become fully integrated in the community and manage the challenges inherent in any effort to effect change. Some observers suggest that home visiting that is offered as a part of large, relatively well-funded service systems — for example, the health care system, public education, or Early Head Start — are the most likely to secure adequate, stable funding.

VI. Evaluation and Continuous Quality Improvement

Program evaluation allows front-line staff, supervisors and administrators, funders, and participating families to know if and how a program of services is being implemented as designed, and the extent to which families and program staff are meeting their objectives. Effective programs use this information to continually refine and improve their services. When planning a program serving expectant parents and families with infants and toddlers that has a home visiting component, be sure to consider — up-front, when the program is being designed and before home visits begin — how to evaluate it and to include evaluation in the operating budget.

Moving Forward

The earliest years of a child's life offer the greatest opportunity to support healthy development and learning. Policy makers can make a positive difference in the lives of young children and families by:

- investing in programs that have a track record of effective home visiting;
- supporting thoughtfully conceived new initiatives that include the six elements of effectiveness described above; and
- ensuring that the level of investment supports rigorous, ongoing evaluation and continuous program.

All children deserve the chance to reach their full potential and *every* community benefits when parents receive the support they need to provide their children with the best possible start in life.

Home Visiting in Action: Examples of Programs that Offer Home Visiting

The following are profiles of 10 programs serving expectant parents and/or families with infants and toddlers. The descriptions illustrate the diverse approaches programs use to offer support to families through home visiting. Some of the programs described are national models with sites in communities around the country; others are projects that were developed for a specific population within a specific community. Programs appear in alphabetical order and are followed by contact information.

The Clinical Nursing Models Project

History and overview: From 1982 to 1987, Kathryn Barnard and her colleagues at the University of Washington School of Nursing developed and implemented a research-based program delivered through home visiting.[1] The major focus of the home visiting was enhancing the mothers positive relationships with other adults and with her child. The program, named the Mental Health Model, was designed to lower the incidence of cognitive and social problems in children from families where the mother was at risk due to a lack of her own social skills and little social support.

Service delivery model: The services began in the second trimester of pregnancy and continued throughout the child's first year of life. Visiting times were negotiated with the mother and occurred about every two weeks from pregnancy to the end of the child's first year. The nurse home visitors helped mothers to develop supportive, trusting relationships with them, their partners, and other family members or friends. Learning about relationship-building during pregnancy prepared the mother for developing a satisfying relationship with her new baby. There was an emphasis on helping the mother understand her baby's communication patterns and how she could best respond to those signals to encourage healthy development.

Staffing and professional development: The home visitor nurses had master's-level training in parent-child nursing. The nurses designed activities to accomplish the major objectives of developing strong, supportive relationships and helping parents feel good about themselves in the parenting role. The services were based on the theories of attachment and relationships, and infant regulation (how the baby experiences and responds to sensory stimulation).

Community collaboration: A comparison model of home visiting was provided by Public Health Nurses working in existing community agencies. Mothers were randomly assigned into the Mental Health Model home visiting or the Regular Public Health Nurse home visiting, which primarily consisted of providing health care information. Nurses from both models collaborated with colleagues in the child care community, Head Start, Child Protective Services, and other community agencies on an individual basis to meet families' unique needs.

Evaluation/research: The mothers participating in the Mental Health home visiting model were compared to a control sample of mothers who received standard nursing follow-up. The group of mothers who received the Mental Health model participated in more of the intended program (80% versus less then 50%). They reached program goals more frequently, experienced less depression, and had more positive interaction with their child.

Funding source(s): National Institutes of Mental Health.

The Clinical Nursing Models Project
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Enrichment Using Natural Resources in the Community and Home (The ENRICH Project)

Services to infants and toddlers with disabilities and their families through Part C of the Individuals with Disabilities Education Act.

History and overview: The ENRICH project has been funded since 1994 by the U. S. Department of Education, Office of Special Education Programs, to develop a model of services and supports for young children with disabilities and their families which includes parents as full partners in the child's service program. Based on the family's concerns and priorities, ENRICH promotes the child's independence and active participation in daily routines and community activities. Parents and other family members are active members of the ENRICH team.

Service delivery model: Project staff initially meet with families in their homes to discuss the family's concerns and priorities. For example, a family may want ideas for how to help their child play more independently, or how to make bathtime easier and more fun. Monthly community activities provide the opportunity for families to get to know each other and have their children fully participate in community resources.

Staffing and professional development: Project ENRICH staff members are experienced professionals from the disciplines of special education, nutrition, speech-language therapy, occupational and physical therapy, clinical psychology and nursing. Although only one or two team members visit the home, the entire team is available to share ideas about how to best serve the children and families.

Community collaboration: An important component of the ENRICH philosophy is the belief that the child's fullest potential is dependent on the strength of the links between the various settings in which the child spends time. Families are invited to participate in regular community outings to support the child's full participation in community settings. When the child reaches age three, project staff help plan and monitor the child's transition from ENRICH into a preschool program.

Evaluation/research: Quantitative and qualitative studies have been conducted in the evaluation of ENRICH. Children who were evaluated before and after receiving services from the program demonstrated substantial increases in motor skills, self-care, and social functioning. Parents also consistently described the services as valuable and contributed to the quality of family life for both the children and other families members.

Funding source(s): ENRICH is funded in part by grants from the U. S. Department of Education, Office of Special Education Programs, Project #H024B40059; U. S. Department of Health and Human Services, Office of Educational Research and Improvement, Project #84307F; Maternal and Child Health Bureau, Project #MCJ08941301; and State and Federal early intervention funds. ENRICH works with local agencies to coordinate funding resources for families.

The ENRICH Project
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HEALTHY FAMILIES AMERICA (HFA)

History and overview: Launched in 1992 by the National Committee to Prevent Child Abuse,* this initiative established a system of support for new parents that is voluntary, family-centered, and strengths-based. Healthy Families America grew out of the experience of the Hawaii Healthy Start program and other family support initiatives for new parents and families facing the greatest challenges. HFA home visitors work to prevent child abuse and other poor outcomes for children by promoting positive parenting, enhancing parent-child interactions, and improving children's health and well-being. HFA programs are available in over 320 communities in 39 states, the District of Columbia, and Canada.

Service delivery model: Services are intended to support parents as well as promote parent-child interaction and child development. Families participate in services on a voluntary basis. Services are initiated prenatally or at birth, and may last up to five years. A standardized screening and assessment process is used to offer services to families facing the greatest challenges in their new role as parents. HFA makes services available to families in the communities they serve and with the parents consent, hospital or clinic records are reviewed and families are interviewed to determine their needs and interests. Local initiatives are developed at the community level to best meet the needs of participating families. All HFA programs offer services at least once a week for the first six to nine months with well-defined criteria for increasing or decreasing levels of service over the long term (i.e. three to five years). Home visitor's caseloads are limited. For example, a home visitor would make weekly visits to no more than 15 families. To assure quality, each program must begin the HFA credentialing process after its first two years of operation.

Staffing and professional development: Home visitors are selected based on their personal characteristics, experiences and education. One hundred and twenty hours of training are provided within the first six months to ensure that program staff possess a thorough understanding of the HFA theoretical framework. This includes basic training in cultural competency, substance abuse, child abuse reporting procedures, domestic violence, positive parenting, and collaboration with other service providers in their community, and other relevant topics. Home visitors receive weekly supervision. Technical assistance and training are provided at both the community and state levels.

Community collaboration: HFA has developed a Community Planning and Site Development Guide for new programs. The guide includes information regarding how to collaborate with other family support agencies in the community. HFA home visitors encourage and promote community collaboration to make a broad array of services available to all parents, and work to coordinate these services so families are best able to meet their needs.

Evaluation/research: All HFA programs are encouraged to implement an evaluation component to contribute to the knowledge base of effective practices. A network of HFA researchers has been established to foster multi-site analysis.

Funding source(s): The Freddie Mac Foundation, Ronald McDonald House Charities, and others. HFA programs utilize multiple and varied sources of federal, state, local, public and private funding sources.

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The Healthy Steps for Young Children Program

PARENTS KNOW THAT YOU DON'T JUST FEED BABIES, CHANGE THEIR DIAPERS, AND PUT THEM TO SLEEP. YOU PLAY WITH THEM FROM BIRTH. WE HELP PARENTS DEVELOP A BALANCE BETWEEN STIMULATION AND THE BABY'S NEED FOR QUIET TIME. TAKING CARE OF INFANTS MEANS MORE THAN CARETAKING; IT MEANS NURTURING THEM TOO. THAT'S OUR MESSAGE TO PARENTS.

Healthy Steps Specialist, Boston, Massachusetts

History and overview: The Healthy Steps program was launched by The Commonwealth Fund in 1994 as a new approach to pediatric primary care.[1] The program, sponsored by the American Academy of Pediatrics, adds a new member to the pediatric health care team, a Healthy Steps Specialist, who provides an array of child development services, including home visiting, to address the physical, emotional, and intellectual development of children from birth to age three.

Service delivery model: Healthy Steps Specialists offer parents a minimum of 6 home visits over three years, beginning soon after the newborn is discharged from the hospital and becoming more concentrated in the early toddler period. In addition to home visits, Healthy Steps Specialists are available in the pediatric clinic for support during health visits, to assess developmental progress, to provide behavioral guidance, to connect families with community resources, to facilitate parent groups, to staff a telephone information line, and to coordinate an early literacy program.

Staffing and professional development: Healthy Steps Specialists typically have training and experience in pediatric nursing or child development. An intensive training institute is required for all pediatric practices interested in implementing a Healthy Steps program. Healthy Steps Specialists participate in biweekly teleconferences with the training staff. Each site receives an annual on-site monitoring visit from the training staff, beginning six months after enrollment.

Community collaboration: Some of the strategies for linking families to community resources include creating a book of community agencies, offering parent bulletin boards in the health care office, providing a pediatric practice newsletter, and developing the Healthy Steps Internet Web site.

Evaluation/research: A national evaluation, which will be completed by 2002, is designed to determine whether Healthy Steps improves outcomes for children, parents, and pediatric practices. If so, the evaluation will then determine whether the program's extra costs prevent current and future health problems and save money in the short-term and in the child's future years.

Funding source(s): To date, The Commonwealth Fund has provided $7.5 million dollars towards Healthy Steps. The initiative has grown to include nearly 60 funding partners nationwide, with a total investment of 24 million dollars.

Healthy Steps for Young Children
Web site: www.healthysteps.com

The Infant-Parent Program, San Francisco General Hospital, University of California, San Francisco

History and overview: The Infant-Parent Program has been at the University of San Francisco since August, 1979. As a service and training program, its primary mission is to provide appropriate mental health services, delivered in the home, that will protect and enhance the relationships between infants, toddlers, and their significant caregivers.

Service delivery model: Mental health trainees from the fields of social work, psychiatry, clinical psychology, and special education work under close supervision from senior clinicians to provide home-based assessment and intervention that includes concrete resource assistance, developmental guidance, advocacy, and infant-parent psychotherapy.

Staffing and professional development: The advanced trainees who serve as home visitors for periods of one or two years participate in weekly clinical supervision related to their work with each family and also participate in a series of seminars on aspects of infant and parent development. As alumni of the program bring its perspective to the new work settings in which they find employment, the model and the underlying perspective spreads. Senior Infant-Parent Program staff provide training for parents, attorneys, judges, Department of Social Service workers, special education professionals, and the early care and education community.

Community collaboration: Referrals come from a variety of community institutions, and the program serves a broadly consultative function to the Department of Social Service, Community Mental Health, the courts, and the child care community, to which they have provided extensive mental health consultation since 1989.

Evaluation/research: Researchers evaluated recent Latino immigrant mothers and their relationship with their infants and toddlers who participated in the Infant-Parent Program®. High-risk mothers and their children were visited in their homes when the children were between one and two years of age, and were compared to a control group who did not receive the home visits. At the time of the child's second birthday, the mothers who participated were more empathic and interactive with their children.

Funding source(s): MediCal (a California based Medicaid program), foundation grants, Mayors Office of Children, Youth, and Families.

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The Ounce of Prevention Fund - Early Head Start and Parents Too Soon

History and overview: Founded in 1982, The Ounce of Prevention Fund invests in the healthy development of babies, children, adolescents and families. In short, the Ounce: (1) develops programs and provides services for about 8,300 children and families; (2) offers specialized training to people who work in community agencies throughout Illinois; (3) conducts research and evaluation to better understand "what works" and (4) advocates for public policy changes that better serve all children and families. The Ounce combines public resources with private funds to develop and test innovative strategies to prevent problems such as adolescent pregnancy, infant mortality, low birthweight and delayed development, school failure, and child abuse and neglect. Services are delivered through a variety of mechanisms, including home visiting.

Service delivery model: The Ounce employs voluntary home visiting strategies in two programs, Early Head Start and Parents Too Soon. Early Head Start is a federally-funded, community-based program for low-income families with infants and toddlers, and pregnant women. Parents Too Soon is a statewide partnership between the Illinois Department of Human Services, the Ounce and 38 community-based sites throughout Illinois. The sites receive state money through the Ounce, which assists with program development by providing technical assistance, training, and monitoring.

Home visitors in both programs seek to build strong parent-child relationships while offering opportunities for the children to grow up healthier and better prepared for school. The home visitors, together with the participants develop service plans tailored to the needs and values of the participant. Home visitors also use methods designed to help focus the young parent on the developing child and to spot early signs of problems in growth and development. In addition, both programs offer group services in which parents can continue to learn about their children's health and development while discussing their lives with peers who face the same challenges.

Staffing and professional development: Home visitors in Early Head Start are hired based on various factors, including education, experience and personal characteristics. They receive additional training and professional development opportunities, both in-house and from external sources. Home visitors in Parents Too Soon are hired by the various community-based agencies

throughout Illinois, but the Ounce sponsors an intensive Training Institute, which includes specialized events for Healthy Families Illinois programs. The Institute, which offers about 90 days of trainings, is designed to build staff competencies in key areas, including: early childhood development; adolescent development; child abuse and neglect; helping relationships; family life education; and supervision and program administration.

Community collaboration: A Policy Council comprised of parents and other community members oversees the Ounce's Early Head Start programs. In addition, the Ounce is collaborating with the Chicago Public Schools and others to build a new, state-of-the-art Early Childhood Educare Center, which will provide services for 182 young children and their families. The Ounce also continues to collaborate with the Chicago Housing Authority and Cook County Hospital to house Early Head Start home-based staff, as well as comprehensive health services. Through its Parents Too Soon program, the Ounce collaborates with 38 community-based sites throughout Illinois.

Evaluation / research: All Ounce programs are evaluated through the collection and analysis of data to link project activities with their proposed outcomes. The Ounce has developed and refined two management information systems designed to integrate the needs and expertise of field staff, agency management, parents and program administrators. Some key findings: While a national survey shows that 14.8 percent of teen mothers become pregnant again within a year after giving birth, only 6.5 percent of Parents Too Soon participants had subsequent pregnancies in fiscal year 1997. Vigorous efforts to promote on-time, complete immunizations has led to a 77.2 percent immunization rate among the children of parents in the program. Finally, teen mothers who entered Parents Too Soon while pregnant were about 20 percent less likely to have low- to very-low birth weight babies than other Illinois teen parents.

Funding source(s): Funding comes from a variety of public and private sources, as well as in-kind contributions. Early Head Start is primarily funded by the federal government, while Parents Too Soon is primarily funded by the State of Illinois. Private donations help to support research and evaluation efforts as well as help to launch new program modifications.

Please note: The Early Head Start (EHS) program described by the Ounce of Prevention Fund is one of over 500 EHS programs funded across the country to provide comprehensive child development services to low income pregnant women and families with infants and toddlers. This federally funded initiative empowers local agencies to provide services designed to meet the needs of families in their community. The use of home visitation as a service delivery mechanism represents only one of the many ways EHS programs provide needed services to families. For more information on EHS, please visit the Early Head Start National Resource Center's website at www.ehsnrc.org

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PARENTS AS TEACHERS (PAT)

History and overview: Initiated by the Missouri Department of Elementary and Secondary Education in 1981 and currently implemented in 49 states and 6 countries, the Parents as Teachers (PAT) program uses instructional home visits, group meetings, regular developmental screenings, and linkage with other services to: 1) assist parents in giving their child the best possible start in life through increased knowledge of child development and appropriate ways to foster growth and learning; 2) give children a solid foundation for school success; 3) prevent and reduce child abuse; and 4) increase parents' feelings of competence and confidence.

Service delivery model: The PAT program provides services to families prenatally to age three. The home visiting component of PAT, seen as the heart of the program, involves personal visits by credentialed parent educators who provide timely child development information, model and involve parents in age-appropriate activities with the child, and respond to parents' questions and concerns. Beginning prenatally or from the time of the child's birth through age two years, visits are made weekly, biweekly, or monthly, depending on family needs and program budgetary restrictions. These services are offered with less intensity from ages three to five.

Staffing and professional development: Parent educators all have backgrounds in education, health, or social services; most are parents themselves. All parent educators receive one week of pre-service training in delivering the PAT model by Parents as Teachers National Center (PATNC) trainers. They are credentialed on an annual basis by PATNC, contingent upon the local administering agency's approval of their service to families and their completion of the required number of annual in-service training hours.

Community collaboration: Each program's community council helps to ensure local ownership and contribution of services. Parent educators are responsible for connecting families with needed services that are beyond the scope of the program.

Evaluation/research: A number of independent evaluations have been conducted, dating b...k to 1985, that attest to significant gains in children's development at age three, carryover of early gains into the elementary grades, and increased parent involvement in their children's school experience. Programs are encouraged to conduct their own evaluations. In 1996, in collaboration with a neuroscience team from Washington University School of Medicine, PATNC undertook a significant revision in the PAT: Birth to Three Curriculum designed to translate the latest research on early brain development in every day parenting practices intended to improve outcomes for children. The Born to Learn™ Curriculum is being field-tested through randomized trials in the St. Louis metropolitan area and in Chicago. Also underway is a randomized trial of the program's effectiveness with high need families.

Funding source(s): PAT programs are offered by school districts, hospitals, churches, and social service agencies as a stand-alone program or as part of a more comprehensive service delivery system, such as Head Start and Even Start, or family resource centers. Funding is often a combination of federal, state, and local dollars, and private monies.

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The Prenatal and Infancy Nurse Home Visitor Program - Kempe Prevention Research Center for Family and Child Health, University of Colorado Health Sciences Center

History and overview: Using a home visitation model that has been developed, refined, and tested over a 20-year period, this program aims to encourage healthier pregnancies, improve child health and development through competent parenting, reduce child abuse and neglect, and improve the life circumstances of participating parents.

Service delivery model: Nurses visit pregnant women in their homes during pregnancy and the child's first two years of life. The nurses use structured, written guidelines for their visits and adapt the program based on an assessment of each family's strengths and needs.

Staffing and professional development: The Kempe Prevention Research Center provides guidance to communities and agencies planning toward program implementation. They also provide nine days of intensive training to nurse home visitors during the first fifteen months of program implementation, and a management information system to monitor program performance and guide quality improvement. The training program incorporates a home-based version of the Partners in Parenting Education (PIPE) curriculum, and all nurse home visitors receive Kathryn Barnard's Nursing Child Assessment Satellite Training (NCAST).

Community collaboration: Home visitors assess families' needs and help them to make the best use of available community resources, such as Medicaid, subsidized housing, nutritional programs, or family counseling services. Another important goal is to provide a connection to a stable source of health care.

Evaluation/research: This program has 20 years of evidence for its effectiveness drawn from longitudinal randomized clinical trials replicated in three cities. The program has been refined over time based on the results of the trials combined with clinical experience. All replication program sites contribute data to a sophisticated Management Information System that permits on-going monitoring and improvement of program implementation.

Funding source(s): The program has been implemented in 70 communities nationwide. State and local governments are funding the program out of existing funds such as Temporary Aid to Needy Families (TANF), Medicaid, maternal and child health grants, child abuse and juvenile crime prevention funds.

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Steps Toward Effective, Enjoyable Parenting (Project STEEP), University of Minnesota

History and overview: The STEEP program began in 1987 as a 5-year study designed to facilitate healthy parent-infant relationships and prevent social and emotional problems among children born to first-time mothers who are at risk for parenting problems due to stressful life experiences such as poverty, social isolation, youth, or lack of education. The program includes both home visits and group sessions.[20]

Service delivery model: Participants in this program were recruited from urban public health clinics. The program begins with home visits initiated during the second trimester of pregnancy, with a focus on helping mothers prepare for the baby's arrival, in terms of both planning for the baby's needs and dealing with the mother's own feelings and expectations about parenthood. Home visits continue every other week until the child's first birthday, and are tailored to the unique needs, strengths and interests of each family. Mothers also participate in parent support groups with other mothers who are enrolled in the program and whose babies are the same age. The relationship between the mother and the home visitor is viewed as the key to effecting change in the mother so she can build a positive relationship with her baby.

Community collaboration: A primary goal of the program is to empower parents to advocate for themselves. STEEP home visitors help mothers to successfully navigate the human service delivery systems in the community and build on their own life skills and support networks.

Staffing and professional development: STEEP facilitators (who both conduct home visits and lead groups in order to build trust and ensure continuity of service) are women from a wide variety of backgrounds who are mothers, have a college education, and who have a strong commitment to working with mothers and babies in high risk situations. Facilitators receive intensive training in attachment theory and research and child development, as well as in issues that multiproblem families face (e.g., domestic violence). Facilitators learn to use videotaping as a therapeutic tool. A staff development model of reflective supervision and consultation is used; facilitators receive individual supervision weekly and participate in group consultation with highly trained supervisors.

Evaluation/research: When mothers who participated in the STEEP program were compared to a control group, it was found that participating mothers experienced less depression and anxiety, better life management skills, better understanding of their child's needs, and an appropriately stimulating home environment.

Funding source(s): The National Institute of Mental Health provided funding for the intervention and evaluation component of the program.

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THE UNIVERSITY OF CALIFORNIA - LOS ANGELES (UCLA) FAMILY DEVELOPMENT PROJECT

History and overview: The UCLA Family Development Project began home visiting with first-time, at-risk pregnant women in 1987. Goals of the program are to improve the self-confidence and independence of at-risk mothers, to help her develop greater support from her partner and family members, and to positively influence the mother's relationship with her child. Stronger parent-child relationships are believed to not only create a healthier bond between the parent and child, but also result in improved learning opportunities for the child.[xx]

Service delivery model: Program design was guided by findings that comprehensiveness, professional staffing, and relatively frequent visits increase effectiveness. Furthermore, the mother's interest in participating in the program and the duration and intensity of the helping process affect the success of the program. Professionals with child development and mental health training visit the pregnant women in their homes during pregnancy and the child's first two years of life. These professionals also conduct weekly mother-infant groups. They follow manuals (Heinicke, 1989) that guide their work as they respond to the strengths and needs of each family and the environment in which they live.

Staffing and professional development: Staff are professionals with child development and mental health training. In-service training includes studying the operational manual, relevant literature, and participating in weekly staff meetings. Individual and group consultation with senior staff continues after new staff begin work with families. All work with families is supervised in on-going group or individual consultation. The Project also provides the personnel to integrate the staff development efforts with the local community clinics.

Community collaboration: The program is an integral part of the pre-natal and pediatric continuity of care at the UCLA Health Centers and the local Community Health Clinics affiliated with these Centers. Established referral connections and resource information banks are used to help families learn how to access such resources in an effective manner.

Evaluation/research: A randomized trial revealed that the program was successful in improving the mother's adaptation, her support system, and the mother-child relationship in the areas of attachment, independence, and the child's sustained involvement in learning tasks.[xxi] The effectiveness of the intervention in a community clinic is now being evaluated.

Funding source(s): National Institutes of Mental Health and local and national private foundations.

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For More Information/Selected Resources

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